example, both severely disabled workers and nonworkers tended to have less than a high school education. It is probable that the more total the disabilities are, the smaller the effect of other factors, such as age and higher education, on work behavior.

Health Characteristics

Disability beneficiaries usually suffer from multiple conditions that, along with aging, compound the degree of disability and often prevent early medical recovery. The severely disabled--both beneficiaries and nonbeneficiaries--often report three or more disabling health problems. They typically suffer from musculoskeletal and cardiovascular disorders, although a significant proportion suffer from respiratory (21 percent), digestive (28 percent), and mental (31 percent) disorders.[14] Since beneficiaries tend to be older than those not receiving benefits, the effects of aging, which reduces the ability to cope with diseases or major impairments, appear to combine with the physical and mental disorders suffered by disabled beneficiaries to cause lasting disabilities for many.

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14. These results were derived from the Social Security Administration's 1978 Disability Survey. The distribution of beneficiaries who have the same major health problems described above differs by program, however. For example, a smaller percentage of SSDI recipients than SSI recipients suffer from mental disorders (about 10 percent versus 31 percent), according to administrative data.

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CHAPTER III. CURRENT ISSUES

This chapter covers four main issues in the disability compensation system. First, the high costs of disability cash benefits are being questioned, since federal disability programs have experienced rapid growth in past years and could expand in the future, especially if any new disability programs were created. Second, despite the addition of new programs and expanded coverage of others, some workers still lack long-term disability protection except under welfare programs. Third, in spite of recent legislative changes, the system still provides high rates of earnings replacement to some disabled persons--for example, some current SSDI beneficiaries who were on the rolls before 1981 and certain recipients of nonwelfare benefits from more than one program. Finally, high benefits from a few disability programs, or high earnings replacements for some beneficiaries, may cause work disincentives.

TRENDS IN EXPENDITURES

Federal disability expenditures grew rapidly during the last two decades but their growth has declined during the last few years. Legislation enacted between 1977 and 1981 and significant administrative efforts have led to decreases in expenditure growth of major programs. Attempts are now being made not only to identify causes of rapid growth and respond to them, but also to test new administrative methods of controlling public expenditures in the future.

Past Expenditure Growth

A pattern of rapid expenditure growth in major disability programs was observed between calendar years 1965 and 1975. During this time, disability payments of major federal programs rose from $4.9 billion to $19.3 billion (see Table 3).[1] The

1. The federal government's share of all public and private disability expenditures grew from 63 percent of cash benefits (continued)

TABLE 3. EXPENDITURES FOR DISABILITY TRANSFER PAYMENTS BY MAJOR FEDERAL PROGRAMS, SELECTED CALENDAR YEARS, 1965-1980 (In billions of dollars)

Compensation Programs[a]	1965	1970	1975	1980	Average Annual Growth Rate 65-75	75-80
Social Security Disability Insurance	1.6	3.1	8.4	15.4	18.0	12.9
Veterans' Compensation	1.8	2.6	4.0	6.3	8.3	9.5
Civil Service Disability Retirement	0.3	0.5	1.3	2.9	15.8	17.4
Supplemental Security Income (for Blind and Disabled)[b]	0.3	0.6	2.6	4.1	24.1	9.5
Veterans' Pensions[c]	0.2	0.4	0.7	1.1	13.3	9.5
Other Federal[d]	0.7	0.9	2.3	3.3	12.6	7.5
Total Major Federal	4.9	8.1	19.3	33.1	14.7	11.4

SOURCES: CBO calculations; Jonathan Sunshine, Disability, U.S. Office of Management and Budget, staff technical paper (1979), pp. 29-30; and the Social Security Bulletin, Annual Statistical Supplement (1980).

a. Major disability programs include those providing long-term disability compensation and exclude all general sick-leave programs.

b. Federal welfare expenditures for the pre-SSI period--that is, grants to states for aid to the needy blind and disabled--are estimated for calendar years 1965 and 1970.

c. Excludes benefits to persons based on attainment of age 65.

d. Other federal programs included are military disability retirement, Black Lung Benefits, Federal Workers' Compensation, and railroad disability retirement.

programs that were most responsible for the growth in federal expenditures were the SSDI, SSI, civil service disability retirement, and veterans' programs. The most significant growth was experienced by the SSDI program, which became the largest single program in costs and numbers of beneficiaries on the rolls.

Causes of Rapid Expenditure Growth. Expanded eligibility, higher participation in the programs, and increased benefit levels were the main factors responsible for the rapid increase in federal disability expenditures. Although the effects were most dramatic in the SSDI program, the same factors caused growth in smaller programs such as civil service disability retirement, federal workers' compensation, and Black Lung Benefits. Many analysts believe a primary cause of rapid growth in participation was the rise in the level of expected cash benefits from major public programs, particularly SSDI.[2] The Black Lung Benefits and Supplemental Security Income programs were new federal programs initiated in 1969 and 1972, respectively, which made persons eligible for disability benefits who were unable to qualify for workers' compensation or SSDI benefits.

Several factors contributed to the growth in the number of SSDI program beneficiaries. First, the number of persons insured in the event of disability increased between 1965 and 1975. For example, the insured status for those under age 31 was liberalized in 1967, making it easier for younger persons to qualify. Second, the rate of disability claims within the insured population increased, although no apparent decline in population health was observed. The increased program participation was reinforced by

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1. (continued)
in 1965 to 68 percent by 1975. State and local government and private programs also grew during this period, although not as rapidly as federal programs. State and local government programs had an annual average growth rate of 11 percent and private programs one of 12 percent. State and local government payments rose from $1.4 billion to $4.0 billion, and private payments rose from $1.5 billion to $4.9 billion.

2. See, for example, Jonathan S. Leonard, The Social Security Disability Program and Labor Force Participation, working paper no. 392, National Bureau of Economic Research (August 1979), and Social Security Administration, Experience of Disabled-Worker Benefits Under OASDI, 1972-76, actuarial study no. 75 (June 1978).

high acceptance rates. Although the number of persons insured by SSDI increased by only 56 percent between 1965 and 1975, the total number of new awards to disabled workers increased over 134 percent--from 253,000 to 592,000.[3] This result was due in part to the easing of eligibility rules during that period, and the availability of Medicare benefits associated with SSDI beginning in 1972, which may have encouraged previously eligible persons to apply.

Increased public awareness of new programs, relaxed program administration, and high unemployment also served to increase participation rates.[4] The publicity associated with the initiation of the Black Lung and SSI programs, as well as the joint administration of these programs with SSDI, served to make more persons aware of their eligibility for SSDI benefits. The number of SSDI applications, for example, increased by a phenomenal 25 percent between 1973 and 1974--the first year of SSI operations. Lenient administration of these programs, as evidenced by a decline in numbers of cases reviewed at the initial determination level, also contributed to the growth in beneficiaries. In addition, increased unemployment may have led to more applications for disability benefits. Between 1973 and 1975, when unemployment peaked, the number of new SSDI awards grew from 6.3 to 7.1 per 1,000 insured workers before dropping to 6.5 per 1,000 insured workers in 1976.

Enactment of ad hoc and then of automatic cost-of-living adjustments during the 1970s caused benefit levels in federal programs, particularly SSDI, to increase more rapidly than average wages. Between 1970 and 1978, for example, legislated adjustments in SSDI benefits caused average payments to increase by 120 percent, whereas average wages increased by only 70 percent. Rising benefit levels not only increased expenditures directly, but in turn further increased participation rates as fewer beneficiaries

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3. Social Security Administration, Social Security Bulletin, Annual Statistical Supplement (1980).

4. See John Korbel, "The Growth in Social Security Disability Insurance and Its Causes," Memo to the Senate Budget Committee and House Budget Committee staffs, December 1978. See also Mordechai Lando, Malcolm Coate, and Ruth Kraus, "Disability Benefit Applications and the Economy," Social Security Bulletin (October 1979), pp. 3-10.

left the disability rolls. While the indexing of benefits in the mid-1970s assured federal program beneficiaries that their disability incomes would rise to offset inflation, it also escalated costs per beneficiary remaining on the rolls.

Reasons for the Present Decline in Expenditure Growth. After a long period of high growth rates, federal expenditures for disability cash benefits are showing signs of growing more slowly. Between 1975 and 1981, new awards from major programs declined, thereby helping stabilize growth in the number of recipients. Initial awards to disabled workers under the SSDI program decreased from a peak of 592,000 in calendar year 1975 to 569,000 in 1977, 389,000 in 1980, and 345,000 in 1981. The numbers of new awards for SSI benefits have also declined substantially, while the eligible population has remained stable.

Tighter administration of program provisions and the public attention given to abuses of the disability system have contributed to the slowing of growth in federal disability benefits. The review of SSDI cases at the initial determination level was improved and the review procedure itself was restructured in 1977; this raised the quality of disability determinations within the SSDI program and reduced the number of new beneficiaries.

The decline in unemployment after 1975 and the stabilization of new programs probably contributed to the decline in expenditure growth. Unemployment rates declined from 8.5 percent in 1975 to 5.8 percent in 1979. It is possible that workers with health problems were able to remain employed during this time. The end of the startup period of new programs and the adjustment to liberalized eligibility in the late 1960s and early 1970s is another likely cause of the decline in program growth in SSDI and other federal programs.

Prospects for Future Expenditures

A further slowing in disability expenditure growth during the next decade may be expected, although changes in the disability system--such as the creation of new programs or higher incidence of disability in the population related to aging--could prevent a decline in real expenditures. Future expenditures will depend on economic and demographic factors and on programmatic factors such as disability denial rates. Continued restraint on the number of disability awards would allow a continued decline in expenditure growth despite high unemployment rates, for example. On the other

hand, expanded eligibility for disability benefits or increased participation among those already eligible for welfare or SSDI could cause new growth in disability cash benefits.

Cost Limitations in Recent Legislation. Laws passed in recent years should work to restrain growth in cash benefits in the near term. Benefit levels under the SSDI program were significantly reduced by the 1977 and 1980 amendments to the Social Security Act. The 1977 amendments established benefit levels for newly entitled beneficiaries based on wage-indexed earnings, thereby correcting a previous flaw in benefit computations, and the 1980 amendments set a lower ceiling on the maximum family benefit levels in SSDI. Also, a requirement for a three-year periodic review of all nonpermanent disability cases should increase the number of recovered persons leaving the SSDI rolls beginning in 1982. The annual savings to the SSDI trust fund resulting from the 1980 amendments' provisions that established a new cap on family benefits and changed benefit computations were estimated to be $1.2 billion by 1985, or about 5 percent of expected outlays.

Other federal laws will also reduce disability expenditures. For example, the Omnibus Budget Reconciliation Act of 1980 (Public Law 96-499) mandates a stricter definition of work disability in the civil service disability retirement program. The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) placed a ceiling on combined benefits received from SSDI and some other public programs (often referred to as a "mega-cap"). This latter restraint on benefit levels applies only to those entitled to benefits after August 1981, however. The Black Lung Revenue Act of 1981 raises the coal tonnage tax to provide more revenue for the Black Lung Trust fund and thereby end the insolvency problem in that program. In addition, it tightens eligibility requirements by eliminating certain presumptions of disability for new claimants, thereby saving an additional $13 million in 1983 outlays.

Expenditures for Occupational Diseases. Federal expenditures for work-caused illnesses could escalate in future years if new federal programs are created to provide benefits to victims of occupational diseases. The public and the Congress have become more aware of the lack of compensation for many workers suffering from disabling occupational diseases. As a result, the federal role in compensating recent victims of black lung disease has

continued beyond its initial curtailment dates.[5] In addition, various pieces of legislation have been introduced in recent years that would establish new programs to compensate victims of brown lung, asbestosis, and radiation-induced diseases. (See discussion of this later in this chapter, pp. 34-36.)

Past trends in disability compensation indicate that in the short run, expenditures for occupational diseases are more likely to be federal than state government responsibilities. State-based programs such as workers' compensation have only recently begun to compensate for disabling occupational diseases on a broad scale, leaving SSDI or public assistance as the only sources of compensation. An easing of eligibility rules within state workers' compensation programs, or the creation of a new program at the federal level, would be in line with the historical pattern for providing compensation to workers permanently disabled by an occupational disease.

Aging of the Population. What effect will the aging of the general population have on the size of the future disabled population and hence on costs in future years? The aging of the general population will tend to increase the number of disability beneficiaries, since the incidence of disability in the general population increases with age. Persons born in the "baby boom" years between 1945 and 1965 will increase the size of the work force until 1985, and therefore increase the number of persons exposed to work-caused disabilities. Also, the worsening of low-rated disabilities in the veteran population as World War II, Korean, and Vietnam war veterans age will probably cause automatic increases in veterans' compensation expenditures, even though new awards will have declined.

Projections of SSDI expenditures in the short run reflect a trend of reduced growth, both in numbers of new beneficiaries and in total costs. The number of persons aged 50 to 64, a group most likely to obtain SSDI benefits, will decline over the next few years before increasing again about 1990. Case termination rates that are higher than recent experience are also projected as a result of increased review of beneficiaries' disability status.

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5. The Black Lung Program was amended in 1972 (Public Law 95-239) with a provision to end payment of new claims after 1981, before subsequent legislation in 1978 deleted the curtailment date.

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The sensitivity of cost to these assumptions is described in the Annual Report of the OASI Board of Trustees.[6] It shows that differences in economic and demographic assumptions--in assumed mortality rates, for example--lead to large differences in projected SSDI expenditures.

DISABILITY COVERAGE AND BENEFITS

This section addresses two related problems: gaps in coverage of disability programs, and lack of benefits even when covered. The coverage problem is twofold: First, not all persons, and particularly not all workers, participate in a program that could potentially provide disability benefits. Second, although workers may be participating, they are often not vested or have not participated long enough to be insured under a program or pension plan. When insured disabled persons fail to receive benefits, the reason is usually that they have been denied a disability determination under specific program definitions.

Lack of Coverage

Approximately one-fifth of the work force--more than 22 million workers--is either without coverage or uninsured by major programs for total non-work-related disability. Although 90 percent of all workers are covered by Social Security, about 20 percent of those currently paying into the system are uninsured for disability.[7] Of the 9.4 million workers lacking Social Security

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6. 1982 Annual Report, Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund (1982). All projections in the Trustees' report assume that the age-sex-adjusted disability incidence rate--the ratio of new awards to the number of insured workers--will decline in 1982 but increase steadily from 1983 through 2000.

7. The number of uninsured workers under Social Security is derived from 1977 and 1979 estimates of covered workers not insured for disability contained in the Social Security Bulletin, Annual Statistical Supplement (1980), tables 42-44. For a more detailed estimate of Social Security coverage, see Yung-Ping Chen, "Special Issues in OASDI," Social Security in a Changing Society (Macahan Foundation, 1980), pp. 129-30.

coverage, a significant portion are also not vested in a private or government program; in 1981, about 13 percent of the 2.7 million federal employees participating in the civil service retirement system were not eligible for disability benefits because they had less than five years in service (see Table 4). In addition, approximately 3.3 million state and local government workers are without Social Security coverage because their employers have not elected coverage; more than 1.5 million of these persons are estimated to be without disability protection under employer plans.

Persons not covered for total disabilities include nonworkers, some federal, state, and local government workers, and many self-employed individuals. Since most disability benefits are associated with employment, groups such as casual workers and housewives are generally not covered by public or private programs. Self-employed workers or domestic workers with low or infrequent earnings often lack coverage. In addition, certain federal government workers are excluded from coverage under the civil service program--for example, certain Congressional, temporary, and appointed workers.

Covered but uninsured workers tend to be young, with little experience in the labor force. Such workers are not insured under SSDI or private pensions because they generally have worked less than one year in covered employment, have low earnings, or are below pension age requirements. Part-time workers and those under age 25 are often excluded from participation in a pension plan or its associated disability insurance plan. Some experienced full-time workers are uninsured, however, often because they have shifted between covered and noncovered employment. For example, federal workers leaving federal employment after more than five years of employment immediately lose disability coverage under federal programs, and may lack insured status under SSDI until they have worked at least five years in the private sector.

Assessing the lack of any disability coverage is a complex problem because the severity of disabling impairments varies widely, and only self-reported data are available for those not drawing benefits. For example, survey data indicate about half of all disabled persons perceive themselves as being only partially disabled--about 10.6 million persons--but only 1.1 million receive long-term disability compensation (see Chapter II). Extended employer sick-leave benefits in the public and private sector often alleviate the problem for partially disabled persons, although these benefits may not last as long as the disabilities.

TABLE 4. CIVILIAN WORKERS NOT COVERED OR UNINSURED FOR TOTAL NON-WORK-RELATED DISABILITY: ESTIMATED FOR 1981 (In millions)

Category[a]	Employed Workers	Not Covered or Uninsured
Workers Covered by Social Security[b]	91.0	18.2
Workers Not Covered by Social Security	9.4	4.1
o Federal Workers[c]	2.8	0.4
o State and Local Employees[d]	3.3	1.5
o Private-Sector Employees[e]	3.3	2.2
Total Workers	100.4	22.3

SOURCE: Social Security Bulletin, Annual Statistical Supplement (1980); Interim Report, President's Commission on Pension Policy (1981); CBO calculations.

a. Civilian workers include all workers age 16 and over in the noninstitutional population and exclude all those unemployed or temporarily out of the labor force in 1981. See Bureau of Labor Statistics, Monthly Labor Review (April 1982), pp. 72-3.

b. An estimated 18-20 percent of living workers covered by Social Security and under age 65 were uninsured in the event of disability in 1977 and 1979. See Social Security Bulletin, Annual Statistical Supplement (1980), tables 42-44. Roughly 90 percent of all workers and 95 percent of all jobs in the United States were covered under Social Security in 1981. Some estimates of coverage are as high as 92 percent of all workers in 1978. See Yung-Ping Chen, "Special Issues in OASDI," Social Security in a Changing Society (1980), pp. 129-30.

(continued)

TABLE 4. (continued)

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c. At the end of 1981, approximately 360,000 of the 2.7 million federal employees covered under the federal retirement system were not insured for disability benefits under that system. About one-half of these persons are assumed to have some coverage under Social Security from either second jobs or previous work, however.

d. Approximately 75 percent of the 13.3 million state and local employees in 1981 were covered by Social Security. The number uninsured by state or local programs is derived by counting 53 percent of state and local employees as having disability coverage under a pension plan. See Appendix B and the Interim Report, President's Commission on Pension Policy (1981), p. 23.

e. This estimate is derived by counting as insured one-third of the 3.3 million casual workers and farm or self-employed workers and employees of nonprofit organizations currently not covered (or not electing coverage) under Social Security. See Yung-Ping Chen, "Special Issues in OASDI," and Appendix B of this paper.

Lack of Benefits

The major reason that impaired persons who are insured for disability do not receive benefits is that they are found not to be disabled according to program definitions. Often a worker is considered only partially disabled or temporarily disabled and thus not eligible for benefits from programs such as SSDI or SSI. For example, in fiscal year 1981, approximately 54 percent of 985,800 applicants for SSDI were denied benefits based on a disability determination. Currently, it is especially difficult for a worker disabled by some occupational diseases to prove total disability and therefore eligibility for long-term benefits, since occupational diseases usually begin as chronic health problems and then gradually become more disabling.[8] In addition, many who seek workers' compensation benefits are unsuccessful because the worker must prove that the disability results from a work-caused impairment that occurred within a specific time period.

A related problem is that persons with similar impairments may meet the disability definitions in some programs but not in others, because of the great variation in these definitions. The definition of disability in the SSDI and SSI programs is more restrictive than in other federal programs. For example, disabled workers may qualify for civil service disability benefits, railroad retirement benefits, military disability, or black lung benefits without having to prove an inability to hold any job in the national economy.

Problems in Covering Occupational Diseases. The main issue concerning occupational diseases is whether existing general programs are adequate or whether special programs are needed. Total disability from an occupational disease is now a compensable disability under a variety of programs such as SSDI, workers' compensation, private pensions, and individually purchased insurance. Coal miners may also be eligible for federal Black Lung benefits.

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8. See, for example, an analysis of problems in compensation for occupational diseases in U.S. Department of Labor, An Interim Report to Congress on Occupational Diseases (June 1980), and L.W. Larson, "Analysis of Current Laws Reflecting Workers Benefits for Occupational Diseases," contract report prepared for ASPER, U.S. Department of Labor (May 1979).

Many contend that since occupational diseases are work-caused impairments, state workers' compensation benefits should be the primary compensation for the resulting disabilities. Although all these programs now recognize responsibility for occupational diseases, the actual coverage and compensation vary by state. Most states now allow additional time periods, three years or more, between the last exposure to the inflictive working environment or the discovery of disability before an application for benefits is required.[9] Difficulties in diagnosing such disabilities means that many disabled workers still do not qualify for benefits, however.

New programs covering occupational diseases have been proposed recently because of concern that persons disabled by such diseases will not actually receive benefits under current programs. Several bills have been introduced recently that would establish federal programs for victims of asbestosis or uranium-ore-related diseases.[10] The concern is based on the fact that current programs tend to consider these diseases as only partially disabling. Even if a disease becomes more disabling in later years, that it results from the working environment may be hard to establish when other factors such as age or smoking habits are considered.

Three major problems evolve from special programs to compensate the occupationally disabled. First, the benefits may overlap with current programs such as SSDI or state workers' compensation. Second, the costs of such programs may become prohibitive, especially if large numbers of workers are immediately eligible for benefits or for retroactive payments. This was the experience in the Black Lung-Part C program; in 1979, for example, after the

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9. State coverage of occupational diseases is outlined in U.S. Chamber of Commerce, An Analysis of State Workers' Compensation Laws (January 1981), pp. 10-13.

10. For example, the House Education and Labor Committee Chairman has introduced a special Occupational Disease Compensation bill in the 97th Congress--H.R. 5735. The bill provides for compensation to victims of asbestos-related diseases through responsible employer-financed provisions. Also, S. 381--a bill to provide compensation for brown lung disease--was introduced in the 96th Congress. Proposals to deal with asbestosis and radiation-induced disorders were introduced in the 96th Congress.

Black Lung Benefits Reform Act of 1977 (Public Law 95-239) eased eligibility rules and required a review of all denied or pending cases, benefit costs increased from $25 million in 1977 and $43 million in 1978 to $615 million. Presumption of disability after a worker has been exposed to a particular working environment for a number of years may be an inherent aspect of special programs leading to serious work disincentives: more and more workers or survivors of probable victims will apply for benefits, and costs will increase.[11] Also, disability retirement may become an alternative to regular early retirement. Finally, the availability of special benefits may reduce employers' incentives to improve the working environment and eliminate the causes of some occupational diseases, unless the total costs of compensation are borne by the responsible employers.

Attempts to solve the problems raised by presumptive eligibility have been only partially successful. The primary focus has been on improving medical diagnoses and defining more rigorously the evidence needed to establish a particular occupational disability. For example, an X-ray or autopsy can establish the existence of disabling black lung disease, but these may not suffice to rule out its existence in early stages.[12] In spite of new methods of medical detection, presumptions of disability may still be unavoidable for certain occupational diseases.

Problems in Determining Disability. A related problem is the perceived discrepancies in disability determinations. A large and increasing proportion of initial decisions in SSDI cases are

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11. The Black Lung Benefits program until recently amended (Public Law 97-119), has been a key example of the expanding costs of categorical disability programs. In 1980, the GAO found 9 out of 10 awards under the Part B program compensated individuals with inadequate medical evidence of black lung disease. See General Accounting Office, Legislation Allows Black Lung Benefits to be Awarded without Adequate Evidence of Disability, report no. HRD-80-81 (July 1980), and statement of Morton E. Henig before the Subcommittee on Oversight, Committee on Ways and Means, on the Black Lung Program and Black Lung Disability Trust Fund, July 27, 1981.

12. See for example, Lorin E. Kerr, "Black Lung," Journal of Public Health Policy, vol. 1, no. 1 (March 1980), p. 59 (Journal of Public Health Policy, Inc., Reprint).

appealed. Reversals of initial denials often encourage more appeals and suggest there may be a lack of uniformity within program administration. A special problem has developed within the SSDI program as reversals of denials of SSDI disability status under the continuing disability investigation (CDI) procedures in the last two years may reduce program savings expected from the CDIs. In 1980 through 1981, reversals of decisions to terminate SSDI benefits were made for about 60 percent of appealed cases.

Litigation in disability determinations arises primarily because definitions of disability are interpreted differently by disabled persons, medical examiners, program administrators, and the courts. The SSDI program's appeals process has become controversial in recent years, partly because of the number of appeals and also because of the great variation in decisions made at progressively higher levels of the process. It consists of two reviews at the state-agency levels, one district review--the administrative law judge (ALJ) level--and a hearing council. In recent years a larger portion of claims have been reviewed at the ALJ level, and over half of the denials reviewed by the ALJ have received favorable determinations. Moreover, some claimants denied at all administrative levels acquire favorable determinations in the courts.

The primary cause of these discrepancies in decisionmaking appears to be the fact that many different factors enter into disability definitions--for example, the use of age, education, and vocational factors as well as medical factors in the SSDI definition of disability. To be eligible for SSDI benefits, a medically disabled worker must be unable to work regularly at any job, considering not only the physical disability but factors such as educational background or previous work experience that also enter into determining the ability to work, especially for those over age 54. Furthermore, it is often impossible to make an accurate evaluation of a disabled person's ability to work. Also, since initial decisions are made first at the state agency level, disability determinations are seldom uniform.[13] Critics of the SSDI program point to the lack of federal control, or lack of

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13. See Deborah A. Chassman and Howard Rolston, "Social Security Disability Hearings: A Case Study in Quality Assurance and Due Process," Cornell Law Review (June 1980), pp. 801-22.

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federal decisionmaking, at initial levels of determinations as a main cause of these discrepancies.[14]

INCOME REPLACEMENT AND BENEFIT AMOUNTS

Income replacement varies greatly among disabled persons, with perhaps the most important variation being the disparity between those with severe or total disabilities who receive long-term benefits and those who do not. There is also wide variation in cash benefits for similar disabilities. For example, income replacement varies among programs because of the different ways programs compute benefits; it also varies within programs, particularly when one compares benefits computed before and after changes in laws determining benefit levels.

This section of the paper describes variations in predisability earnings replacement levels, with much of the emphasis on what appear to be unduly high or low replacement rates. It also discusses the causes of very high and very low rates.

Earnings Replacement Rates

Among disabled beneficiaries, the amount of earnings replaced by benefits varies by program, largely because of the differences in ways they calculate benefits.[15] Programs that relate benefits

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14. The Social Security Disability Amendments of 1980 required the Secretary of Health and Human Services to review some disability decisions rendered by ALJs and to report to the Congress on the uniformity and accuracy of ALJ decisions--a requirement commonly referred to as the Bellmon amendment. The Secretary reported that a significant amount of variation in decisions made by state agencies and ALJs was the result of differences in standards and procedures used by the ALJs and state evaluators. The 1980 Amendments also require a federal review of state disability allowance and continuation determinations on a preeffectuation basis--35 percent of SSDI determinations in 1982--in order to assure greater uniformity and consistency in the decisions made.

15. Changing the definition of previous earnings can affect measured replacement rates substantially. This issue is discussed at the end of this section.

to previous earnings replace a specified portion of the most recent earnings level, or of career or lifetime earnings. (Benefit computations of major programs are described in Appendix A.) For example, state workers' compensation programs will pay two-thirds of weekly wages for total disability as long as this amount does not exceed state maximums. Benefits in programs such as SSDI are related to career earnings in covered employment. On the other hand, some benefits depend on the severity of the impairment, as in veterans' compensation, while welfare benefits are determined by minimum income standards.

There is much concern about benefits that are either very high or very low relative to the disabled person's previous earnings. Earnings replacement may be considered high when benefits provide an amount greater than the income available before disability, since that income is presumed to have been adequate for an individual--even when other family members depended on this income. Income available before disability is usually subject to many reductions, however, such as income taxes, retirement contributions, health insurance payments, and work-related expenses, so that disability benefits can be considered high when they are less than predisability pay but close to previous after-tax income levels. By this criterion, high earnings replacements can mean those greater than 80 percent of previous after tax income, or about 60 percent, on average, of gross earnings.[16] At the other end of the scale, low earnings replacement may be defined as less than one-half of previous adequate income, or less than 30 to 35 percent of predisability gross earnings.

Most disabled workers receive total disability benefits that are not high relative to earnings just before disability. For example, survey data indicate that about 73 percent of those who

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16. After-tax and after-expense income can be replaced by about 70 to 75 percent of gross earnings, on average. This amount would be a complete replacement of spendable income, however. The Health Insurance Association of America has estimated that a reasonable replacement rate, which would have a built-in work incentive and take into account previous work expenses, would be 55 to 65 percent of predisability earnings. See Health Insurance Association of America, Disability Compensation Systems (1979), pp. 1-2. Also, see the general discussion in Social Security Disability Amendments of 1980, S. Rept. 408, 96 Congress (1979), pp. 39-40.

receive disability benefits--or 23 percent of all disabled workers--replace 60 percent or less of their previous earnings (see Table 5). Most severely disabled recipients who receive benefits from only one program have earnings replacements of 60 percent or less--for example, 72 percent of those receiving only SSDI have replacement rates of 60 percent or less. About 3 percent of disabled survey respondents--or 12 percent of beneficiaries--report receipt of benefits exceeding 100 percent of previous earnings, however.

The majority of persons receiving high earnings replacements are low- and mid-level earners, according to survey data. More than 60 percent of male disabled beneficiaries reporting predisability earnings in the 1978 survey had earnings below $6,200 in 1977 wage-indexed earnings (see Appendix Table D-4). The poverty level for a nonfarm family of four in 1977 was $6,191; hence, many recipients of high replacement rates received below-poverty-level disability incomes.

Causes of High Replacement Rates

There are three main causes of high earnings replacement:

- High family benefits from a single program;
- Benefits that are not based on previous earnings; and
- High cumulative benefits from more than one program.

High Family Benefits. Additions to benefits for dependents can result in high income replacement rates. Family benefits are sometimes fixed amounts, but usually are derived as a percentage of the disabled beneficiary's payment; for example, SSDI and Black Lung benefits to disabled workers are increased by 50 percent for one dependent. About 14 percent of SSDI-only beneficiaries severely disabled between 1972 and 1976 received benefits in 1977 that were greater than their previous earnings, primarily because of dependents' benefits for low earners.[17] This ratio is expected

17. Future SSDI beneficiaries will receive lower replacements of their predisability earnings than many current beneficiaries, (continued)